AIDS MEDI-CAL WAIVER PROGRAM (MCWP)
INFORMED CONSENT/AGREEMENT TO PARTICIPATE

APPLICANT'S NAME: Medi-Cal #

I understand that as part of my application for services under the MCWP, the Nurse Case Manager and Social Work Case Manager must evaluate my condition. My Nurse Case Manager and Social Work Case Manager will coordinate the care I receive at home. If I am eligible and choose to participate, I understand that:

1. I will participate in the process for deciding the services that I will receive and will be notified of what services I am to receive and any subsequent changes made to these services. These services will be based on need and availability of funding and that it is cost effective to provide these services. The MCWP is constructed so that I will incur no cost as a result of my participation. However, the MCWP monies will be the last source of payment to provide services; if care is available through another entity, e.g., insurance policy, then that source will be billed before the MCWP program.

2. The Nurse Case Manager and Social Work Case Manager will keep track of my progress and will develop a personalized service plan. The types and quantities of services will be determined through regular meetings with me and interdisciplinary team meetings.

3. I will be asked to provide personal information about myself including name, race, gender, health, and other pertinent information. No identifying information collected will be used against me or will be released without my consent, except as allowed by law. However, summary data based on MCWP participants (*personal identifiers deleted*) may be used by researchers for research and publication. The MCWP is committed to maintaining the highest possible level of confidentiality.

4. Information from my case record will be seen only by approved staff, consultants, and service providers, who will be serving me, or as otherwise provided by law. I understand that my case may be discussed at regular Case Conferences, consisting of MCWP staff, my physician and contractors supplying direct care services to me.

5. My participation in the MCWP is entirely voluntary and I may decide to withdraw at any time and there will be no penalties or loss of other services I am entitled to. My withdrawal will not affect the availability of medical care to me at any time. Furthermore, my doctor may withdraw me from the MCWP at any time if it's in my best interest to do so.

6. I understand that I must meet all MCWP eligibility requirements, including medical needs and condition, and that if I am hospitalized I will not receive MCWP services until my discharge. If I am hospitalized for more than 30 days, I will be disenrolled from the MCWP. I also understand that I must comply with MCWP program requirements as explained to me at enrollment.

7. I agree to cooperate fully with Agency/MCWP staff and care providers and agree to refrain from any verbal or physical hostile, abusive, or threatening behavior. I understand that failure to comply with this provision may result in termination of services.

8. I have the right to ask any questions concerning the MCWP at any time. I will be informed of any significant new information pertinent to my participation. If I have any questions concerning the MCWP program, I may contact my Nurse Case Manager or Social Work Case Manager.

9. I understand that MCWP staff are mandated reporters. I also understand that as mandated reporters they have to report situations such as elder or dependent abuse, child abuse, suicidal ideations, or homicidal ideations. The reasoning for such reports, as well as examples of such instances, has been explained to me.

10. I understand that there are financial caps on some of the MCWP services, including $13,209 per client, per calendar year.

11. Client Initials _____ I acknowledge that I have received a copy of forms *Notice of Action (Denial/Discontinuance)* and *Request for a State Hearing*. I understand these forms will be mailed to me if my application is denied or if I am disenrolled from the MCWP.

    Client Initials_____I acknowledge that I have received a copy of the Agency Grievance Policy

    Client initials_____I acknowledge that I have received a copy of Client Rights.

I have been informed of both the home and community-based services of the MCWP and the alternative to these services and choose to receive MCWP services.

I have read and I understand the above information concerning the program. My signature indicates my agreement to participate in the program. I will be given a copy of this consent form to refer to as needed.

All questions I have concerning the MCWP at this time have been fully answered. If I have further questions, I should contact the MCWP Staff at:_____

Applicant's Signature: Date

Agency Representative: Date: